Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
		FCL012004	4	B. WING		12/0	4/2015
NAME OF I		. 020.200			27ATE 7ID 00DE	1 .2.0	-1/2010
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
DAYS OF COMFORT FAMILY CARE HOME 3421 PINEY ROAD MORGANTON, NC 28655							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE		
C 000	C 000 Initial Comments			C 000			
	Report by Glenn Ho	oppin					
	DHSR Construction Complaint Survey of 9:00 AM to 10:35AM facility. DHSR recofirst licensed on No Care Home for six (to evacuate and resverbal assistance demergency). Based requiring the home the following: the 19 Homes minimum air regulations", the ap Rules 10A NCAC 1: the 1978 North Care Section 409.1(g) - FAt the time of our virequire an acceptable are as follows:	on December 04, M at the above representation of the vember 29, 1985 (6) ambulatory Repond without an uring a fire or other to maintain complicable portions 3G for Family Calolina State Build Residential Care	2015 from eferenced home was 5 as a Family desidents (able by physical or her tion we are pliance with amily Care lards and of the 2005 are Homes, ing Code - Facilities.				
C 103	Construction-Up to	3 Non-Ambs		C 103			
	IV. The Building B. General Constru NCAC 42C .2102) 1. (b) Facilities kee one, two or three cl and/or semi-ambula of the North Carolin	eping up to six re assified as non-a atory must meet	sidents with ambulatory Section 510				
	This Rule is not me At the time of our st facility 's live-in sta of five living in the f	urvey it was obso ff had one child o	erved that the under the age				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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		FCL012004		B. WING		12/	04/2015	
NAME OF PROVIDER OR SUPPLIER DAYS OF COMFORT FAMILY CARE HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3421 PINEY ROAD MORGANTON, NC 28655								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 103	age of 6 is considered census. Your facilitiall-ambulatory residence and considered census. Your facilitiall-ambulatory residence and considered to serve six would require the respond without phong the event of an emecurrently licensed for the event of an emecuration of the event of an emecuric event event of an emecur	red non ambulatory to be part of your recy is currently licensed lents. To allow the lid to remain one of the ust be taken. That you could keep k-all-ambulatory residemoval off site for an analysis to evacuate ysical or verbal assidergency which is where to be part of the part of	sident ed for six the o your dents; this ny is deemed e only e and stance in at you are your under the e so 't have is of y Section Code ilatory. e of the census maximum your 5.4 of the s will a wet 13D with a uding orage and you would	C 103				

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STATE FORM 6899 MD5F21 If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COM	(X3) DATE SURVEY COMPLETED		
	FCL012004	B. WING		12/	04/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
DAYS OF COMFORT FAMILY CARE HOME 3421 PINEY ROAD MORGANTON, NC 28655							
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
(This would allo non-ambulatory non-ambulatory sprinkle the hor	allow for the child to remain. w you to serve a maximum of six residents which will include the child.) (NOTE if you do choose to ne you are required to submit the for a written review prior to	C 103					

6899

Division of Health Service Regulation STATE FORM